Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

THE SAN ANTONIO ORTHOPAEDIC GROUP
400 CONCORD PLAZA DR STE 300
SAN ANTONIO TX 78216

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-12-1414-01

MFDR Date Received
JANUARY 4, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "To prevent permanent nerve damage postoperative continued compression with the need for further intervention decompression of the median nerve will need to be performed. This fracture with no compromise we'll need to be done on an **urgent basis**".

Amount in Dispute: $8,517.28

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "… Texas Mutual declined to issue payment absent preauthorization. However, the requestor's DWC-60 packet has alleged the surgery was an emergency…no payment is due. "

Response Submitted by: Texas Mutual Insurance Co., 6210 E. Hwy 270, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 3, 2011	CPT Code 25609, 64721, 25670	$8,517.28	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the procedures for obtaining preauthorization.
3. 28 Texas Administrative Code §133.2(3) defines a medical or mental health emergency.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of Benefits
   - B5 – Coverage/Program Guidelines were not met or were exceeded.
   - 197 – Precertification/authorization/notification absent.
   - 786 – Denied for lack of preauthorization or preauthorization denial in accordance with the network contract.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 724 – No additional payment after a reconsideration of services.

Issues

1. Was preauthorization required?

Findings

1. 28 Texas Administrative Code §134.600(c)(1)(A) and (B) states, "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) An emergency, as defined in Chapter 133 of this time (relating to General Medical Provisions); (B) Preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care."

   28 Texas Administrative Code §134.600(p)(2) states "non-emergency health care requiring preauthorization includes: (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section."

   28 Texas Administrative Code §133.2(3) defines "Emergency – Either a medical or mental health emergency as follows: (A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) Placing the patient's health or bodily functions in serious jeopardy, or (ii) Serious dysfunction of any body organ or part.

   Review of the documentation finds the requestor has not supported that the surgical intervention met the requirements of a medical or mental health emergency.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 11, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.